Ohio House of Representatives

Finance Subcommittee on Health and Human Services

Ohio Commission on Minority Health
2024-25 Budget Testimony

Wednesday, February 15, 2023
10:00 am

Good morning, Chairperson Carruthers, Ranking Minority Member Liston and esteemed members of the House Finance Subcommittee on Health and Human Services. My name is Angela Dawson. I am the Executive Director of the Ohio Commission on Minority Health, where I am honored to serve.

In 1987, Ohio garnered national recognition as the first state in the nation to create a state agency set aside to address health disparities in Ohio's minority populations. The Ohio Commission on Minority Health is dedicated to eliminating disparities in minority health through innovative strategies, financial opportunities, public health promotion, legislative action, public policy, and systems change.

"Medical advances and new technologies have provided people in America with the potential for longer, healthier lives more than ever before.

However, persistent, and well-documented health disparities exist between different racial and ethnic populations and health equity remains elusive, since appropriate care is often associated with an individual's economic status, race, and gender".[1.]

Health disparities are defined as significant differences in the overall rate of disease incidence, prevalence, morbidity, and mortality rates between one population and another.[2]

Health is influenced by several modifiable factors, often referred to as the "social determinants" or "social drivers" of health, including healthcare access, health behaviors and community conditions like education, jobs, and housing.

Research estimates that 50% of health is attributed to the social, economic, and physical environment, 30% is attributed to health behaviors and 20% to clinical care.[3] Access to and the availability of resources across these factors can limit or increase individual opportunities for health.

Factors impacting health disparities include inadequate access to health care; poor utilization of care; substandard quality of care and social economic status.

The research continues to demonstrate the existence of these persistent disparities over several decades. These health disparities have been further exacerbated by the COVID-19 pandemic.

In Ohio, over the last two years we have heard the declarations from a broad array of stakeholders: academic, community, business, healthcare, policy makers, local and state government leaders affirm that racism is a public health crisis.

In 2020, Governor DeWine introduced the "Ohio's Executive Response: A Plan of Action to Advance Equity", "to reinforce our commitment to advancing health equity and establishing Ohio as a model for justice, equity, opportunity and resilience."

This plan was the Governor's clarion call for recommendations, evidence-informed actions, and policies that individuals, communities, local and state policy makers along with multifaceted industry leaders could implement to eliminate health disparities, racism, and advance equity.

As state agency Director's we are expected to examine our internal and external practices in workforce development, recruitment, promotion, and retention as well as examine our funding practices for equitable distribution and improve our efforts to eliminate disparities and achieve equity.

The Health Policy Institute of Ohio (HPIO), in their August 2020 policy brief entitled "The Connections Between Racism and Health" underscored the many obstacles' communities of color face, including higher rates of poverty, exposure to environmental hazards and overall poor health outcomes.

This policy brief acknowledges racism as a "systemic and policy driver in perpetuating longstanding inequities and disparities that have led to serious consequences for the health and wellbeing of Ohioans of color with profound and pervasive impacts across all the factors that shape our health.

This includes our healthcare, education, housing, food, economic, criminal justice, and political systems, among others".[4]

It is important that we don't only focus on access in our efforts to achieve equity.

Notwithstanding, the significant historical policy change of Medicare, which provides access to healthcare for older Americans, the data still reflects serious disparities in healthcare outcomes and quality.

For example, older black Americans still have higher rates of premature death from diabetes and often received a lower quality of care.

In Ohio, we see this clearly indicated in the data with African Americans having a 48.8 age adjusted mortality rate for diabetes compared to the white age adjusted rate of 26.4. This is also observed in the difference in premature death rates before the age of 75, prevalence and related costs. (See Tables 1 – 5 ODH Data Warehouse)

The Commission has maximized local, state, and federal resources to address the chronic and persistent problem of health disparities that have resulted in escalating health care costs and premature loss of life within racial and ethnic populations.

The Commission primarily funds community-based models that are culturally and linguistically appropriate, and designed to prevent cancer, cardiovascular disease, diabetes, infant mortality, substance abuse and violence which are drivers in eighty-five percent of excess deaths in racial and ethnic populations.

The Commission funds models designed to promote equity, eliminate health disparities, and prevent chronic diseases and conditions. The funded programs are designed to improve health care accessibility, improve health literacy, improve nutrition and physical activity, reduce emergency room use and reduce costs.

To address social determinants and achieve health equity, our chronic disease prevention programs and initiatives use data and tools to segment target populations based on burden and need and implement interventions that can effectively reach these populations.

An example is the diabetes prevention program in Cleveland that implements the CDC recommended Diabetes Prevention Program with required metrics from the Commission.

Demonstration grants are required to implement metrics that align with Healthy People 2030 data driven national objectives to improve health and well-being.

During FY20 and FY21, this program provided services to over 200 individuals who were at risk for diabetes and assisted 51 participants who were diagnosed as prediabetic to transition to a normal A1C. Given the first-year cost of diabetes in Ohio estimated at $16,750, this resulted in a cost saving of over $650,000 and a return on investment of $4.27. **We are seeking to expand this program in two additional counties.**

The equity profiles in the HPIO 2019 Health Value Dashboard highlight that racial and ethnic populations in Ohio face multiple barriers to being healthy and as a result they have significantly worse health outcomes.

The 2022 HPIO Health Value Dashboard ranks Ohio 47th in the nation for health value. Health value is calculated by equally weighting population health and healthcare spending metrics.

According to this report, the inequitable distribution of infrastructure, power, resources, and dollars result in obstacles to accessing education, food, transportation, housing, health care and other resources for Ohio's most at risk groups.

The Ohio Department of Health's - 2015 Impact of Chronic Disease Report, cites that most healthcare costs in Ohio and in the nation are associated with chronic disease and related health behaviors. Chronic diseases present a real threat to Ohio economically, both now and in the future.

The estimated annual economic impact of chronic disease in Ohio is nearly $57 billion. Much of the cost comes from the direct healthcare spending for treatment and management of these disease and risk factors.

For example, the annual healthcare cost of treating diabetes in Ohio has been estimated at $1.34 billion, $1.37 billion to treat high blood pressure and $3.65 billion to treat heart disease.

As significant as these numbers are, the costs to Ohio's businesses are far greater—with more than $43 billion of the $57 billion in total costs resulting from lost productivity in the workplace.

Without action, the future looks even worse. One out of every three children born since 2000 will likely develop diabetes in their lifetime. The total cost of chronic diseases and associated risk factors could cost Ohio as much as $152 billion by 2023.
If Ohioans achieve a modest improvement in *chronic disease prevention* and early detection services, the state could save billions of dollars in healthcare spending and prevent multiple cases of chronic disease.

When we look across the spectrum of chronic diseases and conditions, significant disparities for Ohio's racial and ethnic populations to persevere.

According to the Ohio Department of Health, State Health Assessment:

The chronic disease burden in Ohio is greatly influenced by social determinants of health, which are the social, economic, and physical conditions in the environment in which people are born, live, learn, play, work, and age. Social determinants influence the health of people and communities and affect a wide range of health, functional and quality-of-life outcomes and risks related to chronic disease.

According to Ohio's Plan to Prevent and Reduce Chronic Disease, significant racial disparities in chronic disease outcomes persist in Ohio:

- **Heart disease is the leading cause of death in Ohio. As is true for many chronic diseases and risk factors, significant disparity exists in different populations. For example, in 2011, the heart disease mortality rate for blacks was 218.8 compared to a rate of 186.8 for whites. Both black males and females have higher rates of heart disease mortality compared to white males and females.**

While all Ohioans are at risk for developing a chronic disease, rates of heart disease, stroke, and diabetes in Ohio are higher among blacks.

- Black men had the highest chronic disease death rate in 2016 (700.1 per 100,000), with approximately 39 percent of these deaths occurring before age 65.

- Hispanic Ohioans had a higher estimated prevalence of heart disease than whites for adults aged 18 and older.

- Heart disease is the leading cause of death for people of most racial and ethnic groups including African American, American Indian, Alaska Native, Hispanic, and white men.

- Stroke is a leading cause of death for Ohioans, but the risk of having a stroke varies with race and ethnicity. Risk of having a first stroke is nearly twice as high for Blacks as for Whites, and Blacks have the highest rate of death due to stroke.

- Though stroke death rates have declined for decades among all race/ethnicities, Hispanics have seen an increase in death rates since 2013.

- Asian American Pacific Islanders in Ohio experienced significantly higher incidence rates for liver and stomach cancer than Whites.

- Black Ohioans had the highest mortality rates of any racial group for all sites/types of cancer combined with Black males and females having 21% and 14% higher cancer, mortality rates compared to White males and females, respectively.[6]

It is essential that we work together to prevent chronic diseases which are costly to Ohio, to that end the Commission's demonstration grant initiatives are focused on the prevention of chronic diseases and conditions within racial and ethnic populations.

Similar to disparities in chronic disease, infant mortality reflects the same persistent gap. Infant mortality is a measure of a community's vitality and overall well-being. The infant mortality rate is defined as the death of an infant before his or her first birthday per 1,000 live births.
Healthy People 2030 recommends that a state's infant mortality rate be 5.0 per 1,000 live births.

Ohio has increased its attention and efforts to address infant mortality. These efforts included the prioritization of improving birth outcomes, historic passage of bipartisan legislation, increased infant mortality allocations and the continued efforts of the Commission on Infant Mortality. These efforts link to the work of the Ohio Collaborative to Prevent Infant Mortality (OCPIM), Ohio Equity Institutes (OEI), The Governor's Home Visiting Advisory Council, Ohio Council to Advance Maternal Health and the Ohio Department of Medicaid Sister State Agencies Committee, along with hundreds of additional initiatives across this state.

Based on 2020 data, Ohio is already significantly close to achieving the Healthy People 2030 goal of 5.0 per 1000 live births for white infants which is 5.1 per 1000 live births. However, despite these improvements, persistent disparities are still evident in Ohio's Black infant mortality rate of 13.6 per 1,000 live births, which is more than two times the White infant mortality rate of 5.1 per 1,000 live births for the same year.[7]

In the 2022 March of Dimes Report Card, Ohio was ranked a D+ related to their preterm birth rate of 10.6 for all births based on 2019 data.

In addition, the 2019-2021 average preterm birth rate for whites was 9.6, for Hispanics was 10.2, and for blacks' 14.5.

In Ohio, the preterm birth rate was 51% higher for black women than among all other women, which is 3% higher than the 2020 Report Card.

In 2020, Region V was the worst geographical region in the nation for black infant mortality. In 2018, five of the six states that make up Region V were represented amongst the highest 10 black infant mortality rates the nation. In this listing, Ohio is ranked second highest black infant mortality rate.

Infant mortality continues to be a significant cost driver in Ohio. In 2013, the Department of Medicaid expended $596 million dollars in prenatal and delivery care with two-thirds of this cost, or $373 million dollars, related to the 13.79% preterm birth rate.

In an effort to reduce these exorbitant costs, the Commission is bringing the Pathways Community Hub Model to scale in Ohio. This is a nationally certified, evidence-based, peer-reviewed, pay-for-performance, care coordination model. This model has received endorsement from the Center for Disease Control and Prevention, Agency for Healthcare Research and Quality, the National Institutes of Health as well as the Center for Medicaid and Medicare. In addition, this model has achieved best practice status from the Association of Maternal and Child Health Programs.

The Commission has historically supported our demonstration programs to enhance their models through dedicated training, technical assistance and fostering collaborations with academic institutions to ensure the implementation and sustainability of promising programs.

Our efforts are geared to ensuring that innovative, culturally, and linguistic appropriate programs can be considered for expansion. Our efforts continue to ensure that we provide opportunities to present models that can be piloted and scaled to demonstrate impact in improving health outcomes in racial and ethnic communities.

The Pathways Community Hub Model is an example of the Commission's moving a model from demonstration grant to pilot to scale in Ohio. This model was funded by the Commission in the late 90's and replicated in Toledo and have now been brought to scale to fund twelve Hubs in Ohio.

The Pathways Community Hub National Certification Program (PCHCP) promotes accountable care through the certification of Hub organizations. The Hubs are required to use formal and standardized processes in the delivery of community-based care coordination services. Certification requires the use of the Pathways Community Hub Model with fidelity, which promotes quality care across 21 pathways to measurably improve birth outcomes and links payment to performance.

The pathways are the metrics that focus on successful resolution of an identified risk or issue. The comprehensive assessment identifies the client's risk or issue and then opens the pathways that can address social determinants of health, or barriers to adequate and early pre-natal care.

The model's effectiveness is largely connected to the use of certified community health workers who work with the high-risk mothers and provide care coordination related to appropriate and timely prenatal clinical care. They also address education, employment, housing, behavioral health, and other linkages to essential services. This care coordination effort ensures that the high-risk mother has a connection to the resources that will stabilize the living environment for her infant.

Calendar Year 2022, third quarter preliminary data resulted in approximately 1,291 high-risk pregnant women served and 667 singleton births.

Also, as of the third quarter year to date, the Hubs collectively initiated 15,803 pathways and completed 10,921 pathways or the equivalent of 69% closure rate. Please note, preliminary third quarter Calendar Year 2022 Commission Hub data was compared to preliminary 2020 ODH Data Warehouse birth outcome data as of July 1, 2020.

Collectively for the HUBs as of third quarter for CY22, our overall statewide preliminary black singleton preterm rate was 8.7 compared to the 2022 ODH quarterly infant mortality scorecard for statewide black preterm rate of 14.4.
In addition, collectively for the HUBs as of third quarter for CY22, our overall statewide preliminary black singleton low birth weight rate was 10.4 compared to the 2022 ODH quarterly infant mortality scorecard for statewide black low birth weight rate of 14.0.

The Commission requested a 35% increase to this program to ensure the capacity to serve *3000* high risk pregnant women across the state of Ohio, targeting high risk African American pregnant women. This will allow us to expand this model which has been scaled in the state of Ohio to 23 counties including both Appalachian and rural counties**. (It is important to note that the HUBs are certified to serve in 55 counties in Ohio).**

Currently, all the Ohio Medicaid Managed Care plans contract with this model. Buckeye Health Plan conducted a retrospective cohort study of over 3,700 deliveries from 2013-2017, focusing on the Toledo Hub. This study identified a 236% return on investment with per/member per/month savings for high, medium, and low risk members.[8]

In addition, the study highlighted that high-risk pregnant women in the Hub's area who did not participate in the Hub's services had a 1.55 times greater likelihood of having an infant that needed Special Nursery Care or Neonatal Intensive Care Unit (NICU) Services.[9]

According the March of Dimes, the average length of stay for a baby admitted to the NICU is 13.2 days. The average cost of a NICU admission is $76,000 with charges exceeding $280,000 for infants born prior to 32 weeks gestation.[10] As we seek out strategies to improve African American infant mortality rates, this model has proven it is worth the investment.

The Commission also funds a doula program in Cleveland Ohio. Doula services have been shown to improve birth outcomes, maternal experiences, and reduce racial disparities in maternal and infant outcomes. Doula services are associated with fewer low birth weight babies, lower pre-term birth rates, and higher breastfeeding initiation rates. In addition, these services have demonstrated

improved maternal experiences, higher maternal engagement in care, and improved health equity through provision of culturally contextual and competent care.

Further, the Medicaid focus groups involving Black women indicated a need and desire for doula service coverage which are shown to be cost effective for Medicaid.

During FY 22 the program served over 400 high risk pregnant women. The program preterm birth rate outcomes reflected an African American preterm birth rate of 10.4% compared to the Cleveland preterm birth rate of 16.1%.

The program low birth weight rate outcomes reflected an African American low birth rate of 9.3% compared to the Cleveland preterm birth rate of 16.3%. **The Commission is seeking funds to expand the doula model to two additional counties.**

The Commission was charged through Amended Substitute House Bill 171 and 152 to fund grants that promote health and prevent disease among Ohio's minority populations.

During FY20 through FY22 the world experienced the emergence of the COVID-19 pandemic. While the OCMH funded projects continued to function during the reported period, all were impacted by the pandemic. The pandemic has caused an insurmountable loss of human life worldwide and presents an unprecedented challenge to public health. The economic and social disruption caused by the pandemic is devastating and will most likely reverberate for some time.

During the pandemic, the Commission is working with funded programs to ensure safe and effective program operations. Despite these challenges, our grant funded programs adjusted their programing, transitioned efforts to virtual venues, and continued to support their program participants.

The Commission provides monitoring and oversight of grantee program progress in several ways:

- Grantees are required to submit quarterly program, evaluation, and expense reports.
- Staff conduct annual administrative compliance reviews and provide technical assistance as needed.
- Staff conduct on-site program and fiscal visits that involve the observation of service delivery, review of program and fiscal documentation, evaluation mechanisms as well as the review of internal fiscal procedures and
- The Research Evaluation Enhancement Program (REEP) provides evaluation oversight of major programs on an ongoing basis. REEP is a statewide network of academic and community researchers and evaluators.

<u>Collaboration Efforts</u>

The Commission has participated in multiple collaboration opportunities to include:

- Eliminating Disparities in Infant Mortality Task Force
- Health Policy Institute of Ohio (HPIO) Workgroups
- Ohio Commission on Infant Mortality
- Ohio Collaborative to Prevent Infant Mortality (OCPIM)
- Ohio Medicaid Assessment Survey (OMAS)
- Ohio Department of Health (ODH) - Home Visiting Consortium
- The Ohio Department of Health (ODH) Maternal Child Health (MCH)/ Maternal, Infant and Early Childhood Home Visiting (MIECHV) Steering Committee
- The ODH Maternal and Child Health Block Grant, Children and Youth with Special Health Care Needs (CYSHCN) workgroup
- Disparities and Cultural Competence (DACC)
- Ohio Partners for Cancer Control (OPCC)

2024/2025 As Introduced Budget

The Governor's recommended funding level will allow the Commission to expand our demonstration grant programs and stabilize the remaining five of our grant programs at the FY23 funding levels and maintain the current staffing level of six to ensure oversight of the day-to-day agency operations, grants management and administrative rule compliance.

The Commission continues to be a good steward of the state's resources through focused efforts to increase access to chronic disease prevention programs and expansion of care coordination efforts to reduce preterm birth, which can yield improved health outcomes and a return on investment.

Untreated chronic diseases and unaddressed disparities will continue to result in uncontrollable healthcare costs for Ohio. According to the Health Policy Institute of Ohio, to improve health value, Ohio must address the many factors that impact population health outcomes and healthcare costs.[11]

The future health of our state and our nation as a whole will be largely determined by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations, with minority populations experiencing disproportionate burdens of disease, disability, and premature death.[12]

In summary, the Commission has been visible and active in state and national efforts to reduce minority health disparities and its associated costs. We appreciate the support of our mission and the opportunity to share with you today.

I would like to inform you that I have a profound bilateral hearing loss which will likely require me to ask you to repeat your questions. Thank you in advance for your accommodation. I will be happy to answer any questions you may have at this time.

Table 1

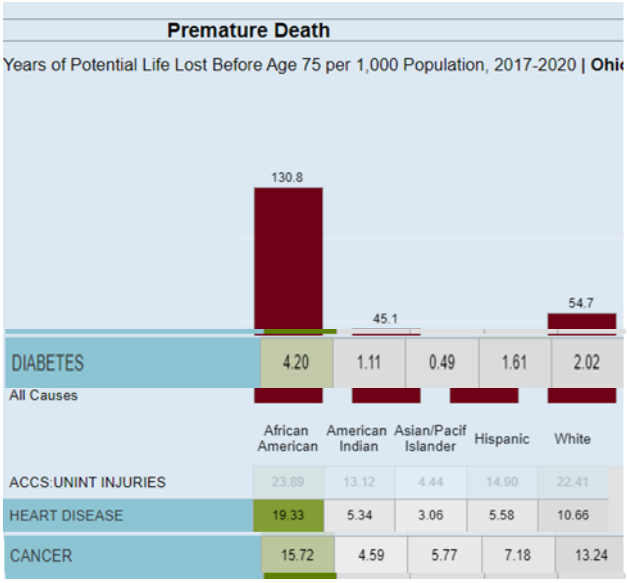
Cause of Death: Diabetes Mellitus

Total Population:	28.3
African American (non-Hispanic):	48.8
White (non-Hispanic):	26.4

Annual age-adjusted mortality rates for the leading causes of death, per 100,000 population, Ohio
Source: Ohio Public Health Data Warehouse

ODH 2020 Comparison of African American and White Mortality Rates

Table 2



ODH Data Warehouse retrieved 2/2023

Table 3 - ODH Data Warehouse retrieved 2/2023

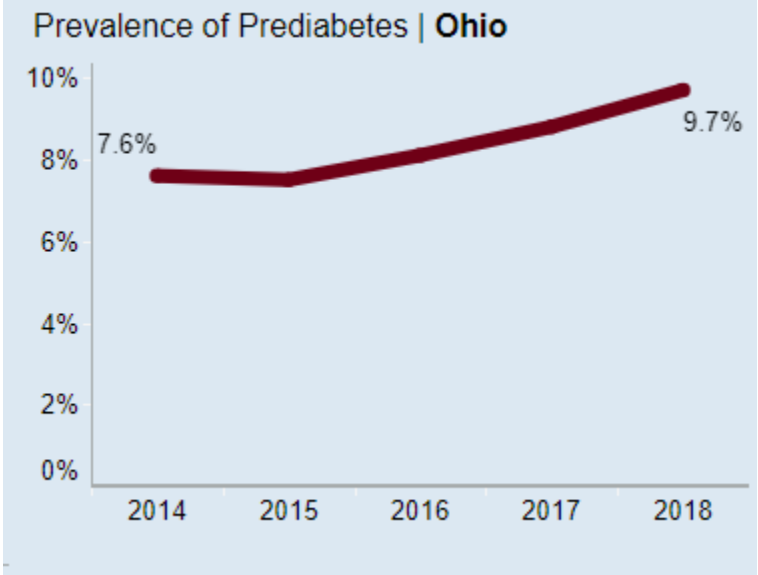


Table 4 - ODH Data Warehouse retrieved 2/2023

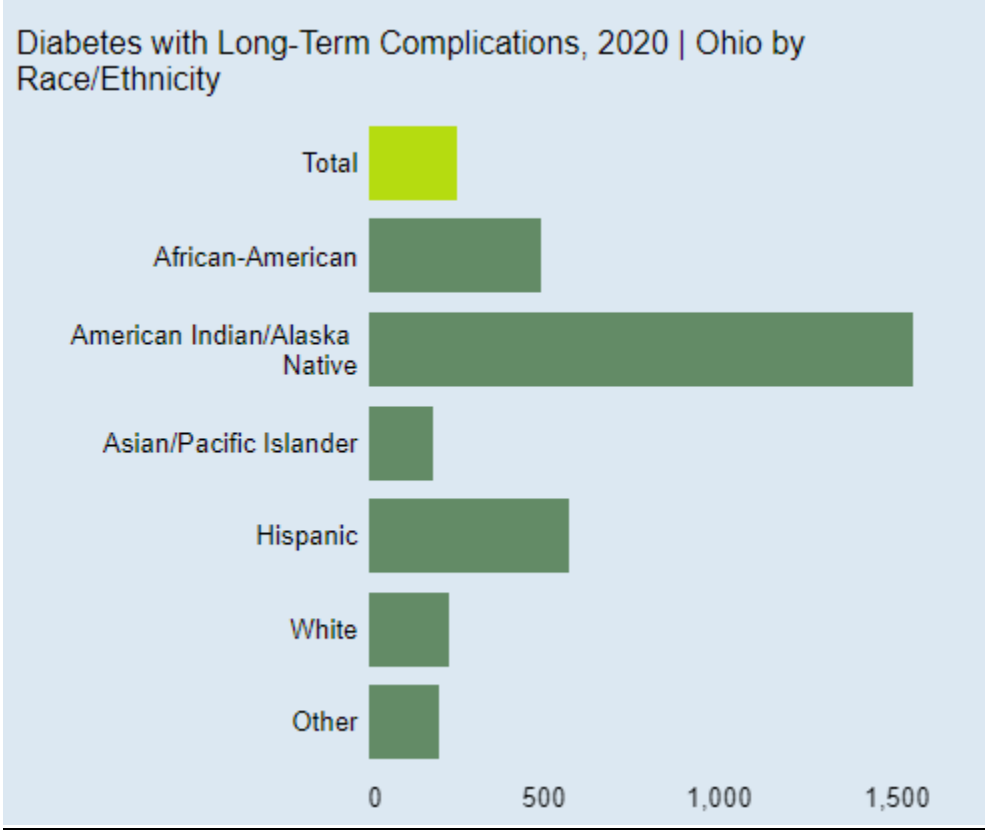
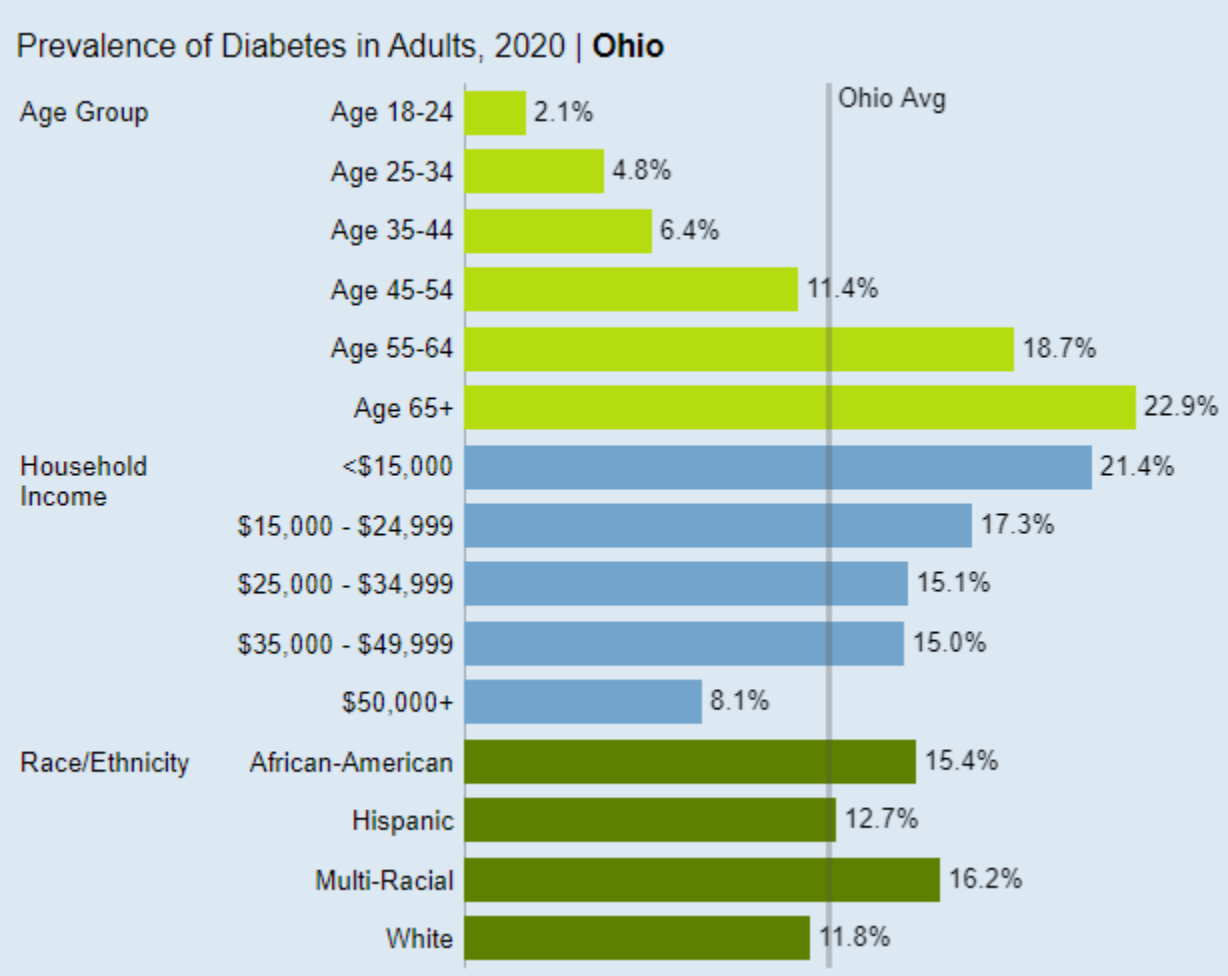


Table 5 - ODH Data Warehouse retrieved 2/2023



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Additional Resources

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